especially amongst those with a non-malignant diagnosis, more clearly needs to be done.

Recommendations from this study suggest staff require palliative and end of life care training, including identifying when death is approaching, along with communication skills training in order to instigate timely conversations with patients and their family members. In addition, further research in this area is highly recommended.

Conclusions Areas of good practice and areas for improvement identified. Suggestions being worked on include introduction of the IPOS for LTNC and cognitive assessments.

P-183 WITHDRAWAL OF MECHANICAL VENTILATION IN MOTOR NEURODISEASE: AN UPDATED EVALUATION OF PRACTICE

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Background Withdrawing mechanical ventilation at the request of a patient with motor neurone disease is complex and challenging. In 2015, the Association for Palliative Medicine (APM) published widely endorsed guidance for healthcare professionals (Faull. Withdrawal of assisted ventilation at the request of a patient with motor neurone disease. APM). We will discuss the updated results of an anonymised data set provided by professionals who have utilised the guidance across the United Kingdom.

Methods Excel analysis of a core data set, defined in the APM guidance, and thematic analysis of free-text comments, submitted by UK-based healthcare professionals soon after withdrawal of mechanical ventilation in any care setting, including inpatient hospice and at home. This is an updated analysis following previously published work (Faull, Wenzel. BMJ Support Palliat Care. 2022; 12(6):e752-e758).

Results Eighty-one data sets were submitted by fifty-eight professionals from across the UK. Frequency and dosage of opioid and sedative medication required pre- and post-withdrawal of the mechanical ventilation was similar to that shown in previous analysis. Ten patients lived for longer than eight hours following withdrawal of mechanical ventilation. These patients were of varying ages and had varying dependency on mechanical ventilation prior to withdrawal. All ten patients were using non-invasive ventilation as opposed to tracheal ventilation.

Discussion The updated results of this evaluation of practice provide new information on patients who have a prolonged time to death following withdrawal of mechanical ventilation in motor neurone disease. We will discuss the reported experiences of healthcare professionals, as well as the experiences of family members and the implications for service delivery particularly when there is a longer time to death following withdrawal.

P-184 MUSIC AND MOVEMENT FOR PEOPLE WITH PARKINSON’S DISEASE AND THEIR CARERS: A Dalcroze Eurhythmics Pilot Study Within a Hospice Environment

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There is a growing call for embodied, non-invasive approaches to rehabilitation which can improve social relationships as well as psychological and physical wellbeing. This call is supported by an emerging evidence base demonstrating the impact of psychosocial approaches, including music and movement,
al ready found to be beneficial to those with neurological and other disorders.

This practice-led study aimed to explore how a pilot music and movement project was experienced by people with Parkinson’s disease and their carers within a hospice environment. Over two months, we offered six weekly sessions as part of the expanding Wellbeing service at St Columba’s Hospice Care. Eight people with Parkinson’s disease and five carers participated. The study followed a specific music and movement approach (Dalcroze Eurhythmics) that, in addition to psychosocial aspects, considers physical functions of balance and gait as well as executive functions and alertness and concentration. Data collection involved baseline participant information, weekly ethnographic participant observation, as well as a participant focus group and an interview with the facilitator at the end of the project.

The findings highlight the perceived impact of music and movement on people’s sense of psychosocial and physical wellbeing. Participants’ reports of physical and psychological safety, their re-connection with their sense of self, experiences of joy and playfulness, and the relational reframing of movement transcending functional limitations are some examples of emerging thematic areas. These findings are discussed in relation to contemporary literature to consider strengths and drawbacks for service development in this area of work for hospices.

**P-185 USE OF HIGH FLOW NASAL OXYGEN ON A HOSPICE INPATIENT UNIT (IPU) FOR SYMPTOM CONTROL IN PATIENTS WITH INTERSTITIAL LUNG DISEASE**

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**Background** Interstitial Lung Disease (ILD) can have a rapidly progressive course with hypoxaemic respiratory failure, intolerable breathlessness and anxiety at end of life. Often, morphine and midazolam are administered via syringe pump to achieve symptom control with a degree of sedation. In the Acute Trust during the pandemic, High Flow Nasal Oxygen (HFNO) (Frat, Goudet, Girault. Rev Mal Respir. 2013;30:627–43) provided symptom relief even when the lungs were severely impaired. Prior to introduction of HFNO on IPU, the maximum oxygen that could be delivered was 15L via a non-rebreathing mask. The use of high flow rates via nasal cannula causes drying/bleeding of the nasal mucosa and the cold temperature is frequently intolerable.

**Aim** To introduce HFNO for use in a hospice to improve symptom control in patients dying from ILD when appropriate.

**Methods** A patient in the Acute Trust was transferred to the hospice for end of life care. Despite receiving 15L oxygen via a non-rebreathing mask, his oxygen saturations were below 80%. Any care triggered panic attacks and desaturation episodes down to 58%. His deterioration prior to transfer had been very rapid. He had been in hospital for 3 months. He found morphine helpful but did not tolerate benzodiazepines. The company supplying the HFNO system provided training to staff.

**Results** HFNO provided immediate relief with improved oxygenation, reduced respiratory rate, reduced anxiety and an ability to tolerate care. HFNO was well tolerated and the patient/family have spent quality time together. He is alive 3 months after transfer but is slowly/steadily deteriorating.

**Conclusion** HFNO is an effective way to provide symptom control in patients with end stage ILD, improving oxygenation and decreasing work of breathing and respiratory rate (Mauri, Turrini, Eronia, et al. Am J Respir Crit Care Med. 2017;195:1207–15; Vargas, Saint-Leger, Boyer, et al. Respir Care. 2015;60:1369–76). It is well tolerated (Cuquemelle, Pham, Papon, et al. Respir Care. 2012;57:1571–7) and its use has been pivotal in providing good end of life care for this patient. However it should be used judiciously and guidelines/indications for use should be developed.